Ratchet Patrol

A Monthly Networking Newsletter about Experienced Anomalous Trauma for Interested Scientists

Volume 1, Number 1
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Ongoing Discussions About...

Send contributions for publication,
and requests for subscription information, to:

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Forum

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Ratchet Patrol: A Philosophy

The answer to the first question you have about this newsletter will answer all the rest. The question, I suspect, is, "What the hell does the NAME mean?"

The name occurred to me as I was reading through an issue of THE SKEPTICAL ENQUIRER. One of the qualities of 'believers,' the author said, was what he called the 'Ratchet Effect':

" The brains of 'believers' operate like ratchet mechanisms: Phenomena that reinforce beliefs wind the ratchet's grip tighter. But negative evidence, like reversing the winder of your watch, produces no corresponding unwinding and loosening of the ratchet's hold."

This struck me as a perfect physical model of the reaction that our work triggers in so many people. What unites us across our differing professions and opinions is that we are consciously trying to approach the abduction issue in a 'ratchet-free' way.

Serving on the Ratchet Patrol implies an understanding of one basic principle of information theory:

The importance of information is directly proportional to its improbability.

People who have a lot of ratchets active support the opposite premise, that the importance of information is directly proportional to its PROBABILITY.

It's tough duty, but someone's got to do it.

(Footnote: In the letter many of you received about this project, the newsletter was called FAIR WITNESS. Some of you were kind enough to let me know that this name is already being used by Bill Moore. So, if you think "Ratchet Patrol" is a dumb name, you know who to blame).

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Forums: How They Work

RATCHET PATROL is intended to provide a medium for regular communication and exchange of information relating to the abduction issue.

RP works like a set of parallel chain letter, or a computer bulletin board. RP consists of a number of FORUMS. Each FORUM is a series of comments, proposals, rebuttals, and observations on a specific topic or question. New FORUMS can be started at the suggestion of any reader.

Ponder the contents of each issue. You may participate in the debate by writing down your contribution to an existing FORUM, or by presenting a question or observation that will start a new FORUM. Forward your comments to me, and I will include them in the next issue.

I function as the moderator in this debate. I organize the contributions to produce a readable newsletter, and distribute a new edition every month. I do not intend to edit material. If you send me a contribution, I will put it in the next issue of RP.

Nobody likes a windbag, so keep the contributions concise. One typewritten page in any one FORUM is a longish contribution. No more than the first two pages of a contribution to any one FORUM will be published. And, of course, you can participate in as many of the FORUMS as you want.

I am also prepared to distribute information (larger articles, or notices of upcoming meetings, for instance) within the body of the newsletter or as inserts to an issue. This will be done gratis for the time being (for members). A membership list will be published in each issue so you can see where your material is going.

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Membership Criteria

The RATCHET PATROL is intended for mental health professionals, UFOlogists, scientists of all disciplines, and legislators. The quality of the discussion is of paramount importance; the size of the membership is important only insofar as it enhances the quality of the discussion.

To this end, it is important to have some criteria for membership in place and a mechanism to administer it fairly. Both of these are open for discussion and debate.

Since this is supposed to be a scientific analysis (in the best possible use of the word "scientific" - collecting data, forming and testing hypotheses), participants should be able to bring some skill or knowledge to the group that will enhance this effort.

Interest in the UFO or abductee issue alone is not, in my opinion, sufficient justification to gain membership.

I don't want to make entrance requirements too rigid right now. That is why it makes sense to have a membership board to validate entrance requests.

The membership board could consist of:
-one mental health prof. representative (myself), and
-one UFO research community represenative (Richard Hall), and
-one person who is neither of the above (any ideas?)

Requests for membership and subscriptions or sample issues should be forwarded to me, and I will distribute them to the board. This process should take no more than a couple of weeks, since rate of transmission of information is so important to the success of a project like this.

I welcome advise, suggestions, criticisms on the above ideas. I also encourage you to suggest names of people who you think would be interested in receiving RP and would enhance our ongoing discussions.

I am requesting a contribution of $1 for a sample issue, or $20 for a one-year subscription (12 consecutive issues). This partially covers postage and reproduction costs.

My address is on the front page. Hope to hear from you all soon!

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Membership List

Biographical Sketches

I would like each member to send me a short bio (one page MAX), describing their background, training, current work, personal views on the issues, and anything else they would find appropriate. This will help increase the networking potential and sense of community among the various disciplines that we hope to bring into the work.

Some participants may prefer to be anonymous, for professional reasons that many of us are familiar with. As long as these people identify themselves to the board, I see no problem with pseudonymous participation.

I would also like to include, in each issue, a list of members. IF THE ISSUE YOU ARE READING WAS MAILED TO YOU, YOU WILL BE INCLUDED ON THIS LIST IN ISSUE #2 UNLESS YOU WRITE TO ME EXPRESSING YOUR DESIRE NOT TO BE!

Here are this month's biographical sketches. Collect them! Trade them!

MARALYN TEARE, M.S., M.F.C.C.
323 E. Matilija, Suite 112-170
Ojai, CA 93023

Maralyn Teare is a licensed marriage, family and child counsellor in private practice in Los Angeles, Orange, and Ventura Counties. She is also clinical instructor of psychiatry at the University of Southern California School of Medicine, Anxiety Disorders Clinic, Los Angeles, California.

In addition to an active general psychotherapy practice, she specializes in the treatment of phobias, panic attacks, anxiety disorders, and post-traumatic stress disorder using a highly individualized, multifaceted, and systematic approach within the context of each person's unique perceptual experience.

Maralyn is recognized nationally and internationally for her contributions to the advancement of treatment and science. In 1985 she was elected into membership of the prestigious New York Academy of Sciences following the presentation of a pioneering paper on the conceptualization and treatment of phobias. In .1986 she was invited to participate at the Soviet-American Conference on the Family in Moscow. In 1988 she served on the psychological task force as a citizen-diplomat to the First Soviet-American Citizen's Summit, Washington, D.C. She is presently listed in more than a dozen Who's Who, including the World Who's Who of Women, and in 1986 was chosen as one of 150 world-wide recipients of the American Biographical Institute's Commemorative Medal of Honor for outstanding achievement. Most recently she was elected into full membership of the highly regarded Society for Scientific Exploration, formed for the study of Anomalous Phenomena. She has been invited as a guest specialist and advisor in numerous nationwide television talk shows, and in her 1984 appearance on "Woman to Woman" NBC won an Emmy. She is a member of numerous national and international professional organizations that are on the cutting edge of scientific exploration, as well as networking effectively in promoting a peace-oriented consciousness, through social, scientific, political and personal change.

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Her big questions around this area relate to perception, memory, hemispheric interventions, and the manipulation of the electromagnetic spectrum, NDE, shamanism, and the means by which altered states are induced.

DAVID A. GOTLIB, B.Sc., M.D.
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Toronto, Ontario, M4T 2P7
Canada

I am an MD currently working as a GP psychotherapist specializing in treatment of depression and anxiety disorders. I use both psychotherapeutic and pharmacotherapeutic techiques where appropriate. Hypnotherapy for a variety of problems makes up a large part of my practice. I run a small multidisciplinary health clinic, consisting of an acupuncturist & Chinese herbal medicine specialist, a massage therapist, and other psychotherapists.

I have a bachelor's degree in Computer Science, and prior to entering medical school I worked for three years as a computer network designer for Bell Canada's computer communication arm.

I have never had an anomalous experience myself. My interest in this area stems from some referrals for hypnosis I received about three years ago. These people had had abduction experiences, and they had tried to get help from a number of physicians before coming to me. Those physicians had refused to see them because they were too "weird" or "crazy." At that time I was less interested in their particular experience than the fact that they were obviously in need yet denied medical care in an arbitrary manner.

ROBERT N. SOLLOD, Ph.D.
Associate Professor of Psychology
Cleveland State Unviersity
Cleveland, Ohio 44115

I received a Ph.D. in psychology at Columbia University in 1974. In addition to my teaching and research activities, I conduct a part-time private practice in psychology. My interests include psychotherapy integration, transpersonal psychology, and literacy training. An interest in the process of spiritual emergence has led me to the exploration of the subject of anomalous experiences, and I have been working to develop a psychotherapeutic approach to a variety of types of anomalous experiences. I have focused upon the phenomenology and experiential meaning of such processes rather than upon their reality status per se. I am open to a wide range of possible explanatory constructs, even though most of them cannot easily be proven or disproven. Also, I think that there is a broad range of anomalous experiences with many possible associated meanings.

R. LEO SPRINKLE, Ph.D.
1425 Steele St.
Laramie, WY 82070

Leo is Professor of Counselling Services at the University of Wyoming-Laramie. In addition, he is associated with the Counseling and Career Development Centre, Laramie, Wyoming, as psychologist and Coordinator of Training. He trained as a counseling psychologist: BA (1952), MPS (1956)., University of Missouri - Columbia (APA approved program).

Leo witnessed UFOs, with others. in 1949 and 1952. After the second sighting he began to investigate the literature on UFO reports. In

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1962 he joined APRO and NICAP (Aerial Phenomena Research Organization; National Investigations Committee on Aerial Phenomena). He began to consider ways that psychologists could contribute to UFO research, as well as to study the personal characteristics of persons interested in UFO reports.

In 1964, at the University of Wyoming, he began a study of UFO abductees/contactees, including their claims of ESP and UFO experiences, and their responses to psychological inventories. In 1967, he began to provide hypnotic sessions for persons who claimed UFO abduction encounters. He has assisted more than 175 persons who have explored their UFO memories in hypnosis sessions.

Leo says that after 31 years of UFO investigations, he has come to these tentative viewpoints:

"(1) I believe that UFOs exist.
(2) I cannot prove to anyone that UFOs exist.
(3) UFO research is always frustrating, often fearful, sometimes fun.
(4) Psychotherapeutic services and social support for UFO Experiencers are helpful to them in accepting the reality of these experiences and in their understanding of the silliness and the significance of these experiences.
(5) There are many skills that can be useful to the psychotherapist who works with UFO Experiencers, but the main attributes are courage, curiosity, and compassion.
(6) I appreciate the willingness of UFO Experiencers to share their information, and the willingness of professional colleagues to assist UFO Experiencers."

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What Are The Questions?

What kind of data should we be collecting? What questions should we be asking?

I suggest that we have already amassed enough cases to demonstrate without doubt that a phenomenon exists which is not explained by our available paradigms. Simply collecting more of the same kind of information will not be particularly useful.

For instance, we do not yet know the following:
-prevalence (how many people in the population has this happened to);
-incidence (number of new cases per year)
-risk factors (characteristics of an individual, or a location, that affect the probability of having such an experience)
e.g religion, urban/rural, intelligence, cultural/ethnic background, ...

Part of the challenge is to find something objective and measurable about abductees.

For instance, many people I have spoken to in recent months have referred to the importance of the electromagnetic field; they suggest that distortions in the interaction of the earth's field and an individual's personal field may be relevant in some way. Do any of you know anything about this? What things should be measured? What equipment should be used?

What are YOUR big questions? What areas of the phenomenon do you think we should be concentrating on? What areas have we neglected?

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Psychotherapy of Abductees

What do you see as the issues involved in treating a patient where the true nature of the experience is fundamentally in doubt? What is the endpoint? Does the treatment of a suspected wannabe differ from that for a more "legitimate" abductee case?

And how do you decide when an abductee requires treatment ?

My philosophy has been to help them integrate the experience in their lives, through talk therapy, hypnotic regression where indicated, and reassuring them that while we do not fully understand the phenomenon, their experience is shared by many others; they are not psychotic, not fabricating, and not hallucinating.

A recent experience with a patient highlights some of these issues. K was referred to me for therapy around her abduction experience by another abductee who was familiar with my work. K told me she had no memories or worries about UFOs or abductions until reading INTRUDERS. Actually she only got through a few chapters before feelings of intense fear and anxiety compelled her to stop.

She called a local UFO research organization. The man on the phone was sympathetic and said he would dispatch a three-person "support group" to meet with her.

A week or so later, this support group arrived at her home. The women explained that they were "psychics," and asked if they could tape-record the session. Over the next three hours, K related her (at that time vague) memories of UFO encounters and childhood experiences, as well as significant detail about her personal life, troubled marriage, and past psychiatric treatment. She observed the support group critically studying her artwork and clothng, and exchanging knowing glances.

By the time they left, they had told her that she had too active an imagination. Hers was not a credible case, they said, because of her past history of emotional problems, her "flaky" mode of dress and artistic taste. She should learn to be more down to earth and think less about UFOs.

This left K humiliated, depressed and angry. The first few sessions with me were devoted to dealing with the shame the so-called support group had created.

A byproduct of our efforts to promote the study of Anomalous Trauma is that these unprofessional groups may be the first contact for many people. Out to gather data and find the "smoking gun" at the expense of the innocent people involved, people will end up getting used and hurt. I don't know how much of a problem this is in the U.S., but in my area (Toronto, Canada) it is always on my mind.

What are your opinions on this?

In a similar vein, say the therapist is first contact for an abductee. There are aspects of the case outside the therapeutic domain that warrant investigation, but the therapist is trained in clinical issues, not in field

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Psychotherapy of Abductees

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work. Referral to an competent UFO investigator may be a good idea. How important to the patient's therapy is it to do the field work? What guidelines should be used?

If the therapist decides it is in the best interests of the patient, there is still the legal and ethical responsibility to be satisfied of the competence of the investigator to be called in. How is that to be done?

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Ethical Issues

This is a draft version of the paper produced by the Ethics Committee of you-know-what-group. Since most if not all of the people who participated in its development are on the RP mailing list, I thought it appropriate to include it here as the nucleus of a code of ethics for this work.

Please feel free to comment or criticize any or all of this document. It is presented for discussion and debate, like everything else in RP.

0. SCOPE OF THIS REPORT

This paper discusses ethical guidelines for the research and treatment of people who have reported "Experienced Anomalous Trauma."

It is not intended to apply to social situations where neither research nor treatment is occurring. Nevertheless, the principles embodied in these guidelines are no less relevant to such gatherings. Two points in particular need to be stated. First, these social situations should be clearly differentiated from a "therapeutic" (in a clinical sense) situation. Second, these groups are encouraged to make use of the resources offered by those participating in this study.

I. INVESTIGATOR AND THERAPIST - A DEFINITION OF ROLES

We consider an "investigator" to be concerned with the collection and analysis of data pertaining to the experience. A "therapist" is concerned with the diagnosis and treatment of physical and emotional disorders.

Realistically, these two functions are only partially separable at this stage of the evolution of the abductee issue. In the course of his or her work, an investigator will be developing rapport and providing emotional support to the abductee, beginning the process of "therapy." Similarly, a therapist may be in a position to obtain more data about the incident during the therapeutic process.

Although the terms "caregiver" and "therapist" appear in the body of this paper, the principles below apply to "investigators" and "therapists" alike. We hope that all involved in this work have those most valuable of professional attributes: The willingness to practice skills in which they are competent, and the wisdom to recognize when they need help from another source.

II. THE IMPORTANCE OF A CODE OF ETHICS FOR ABDUCTEE INVESTIGATION AND TREATMENT

The first question we must address is: What is the purpose of having a "code of ethics" for this project? A number of books have been written and a number of UFO investigative organizations have been at work for many years. They seem to have gotten along OK without such a formalized set of rules.

Up to now much of the work has been addressing the issue from the point of view of the UFOlogist: The abductee has had a purported close encounter with objects and beings that are the focus of a hotly pursued investigation, with broad implications in every field of human experience.

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Less attention has been paid to the human factor:

-What are the rights of such abductees in such an investigation?
-What are their needs?
-Do they require "treatment?"
-What treatment is best for them?
-What protection do they have?
-How will investigation of their case benefit them?
-How could investigation of their case harm them?

The ethics of abductee work revolve around two issues: First, the desire to conduct a scientific study of the phenomenon and discern its true nature; second, the need to understand how best to assist abductees in dealing with their experience. The two are interrelated: Without understanding just what is happening, the task of formulating diagnosis and treatment plans can at best be incomplete. We need more data, scientifically assessed, to be able to decide who (if anyone) needs therapy, what kind of therapy is most helpful, and what constitutes a satisfactory endpoint of such therapy.

As enticing as the mystery is, basic rights and freedoms need to be respected. As caregivers it is our responsibility to practice our craft in a professional manner and follow a course that is ethically sound. We are responsible to our patients, our licensing and regulatory organizations, and ultimately to ourselves. It is with this perspective that we address the question of ethics in abductee research and treatment.

III. RISKS

This is not meant to be an exhaustive list of potential problems. Rather we wish to highlight different aspects of the situation that should be considered at all times.

1. The social milieu. How will the client react to the possible rejection or alienation from family, friends, fellow workers if they learn that he or she is a self-proclaimed "abductee"? How will the client deal with a perceived need to keep it a secret?

2. As the boundaries of the client's realities are challenged, how will he or she react? Are we prepared to help the client forge a new set of boundaries?

Are we responsible if the client
-seeks out a fringe belief system like a religious cult that alters his or her relationship with their previous social structure?
-suffers anxiety or depression as a result of our work?

3. Underlying psychopathology may not be diagnosed, and therefore not treated, because it is masked by, or coexists with, an abductee scenario.

4. Underlying psychopathology may be exacerbated by the investigation process. For instance, hypnosis is relatively contraindicated in schizophrenia (especially paranoid psychoses with ideas of influence) and depression (especially with suicidal ideation).

5. Hypnosis is a therapeutic tool, and should be used only for appropriate indications. Hypnotic regression for the sole purpose of retrieving "abduction material", without a clinical reason to do so, is inappropriate.

Our primary responsibility as therapists is to care for the patient; as the Hippocratic Oath says, "above all, do no harm." We must respect the potential for harm to the patient in this exercise; to refrain from doing so is to accept responsibility for avoidable harm that may come to patients in the process of

Ethical Issues
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"expanding our database about abductees."

IV. COMPETENCE

IV.1. HYPNOSIS - TRAINING

Lack of standardisation of training is a major problem: In the United States, there are only three states which have legislation regulating who can and who cannot practice hypnosis. Legislation in Canada varies by province. (Only Australia and Israel have national regulations regarding hypnosis).

Both the American Society of Clinical Hypnosis and the Society for Clinical and Experimental Hypnosis offer training in hypnosis. The minimum requirement for a "basic" course in hypnosis according to the American Society of Clinical Hypnosis is 20 hours of training.

We suggest that such a basic course from either organization or one of their affiliates be considered a minimum requirement for practicing hypnosis in the context of our study.

Those practicing hypnosis with abductees should be mindful of the potential for emotionally charged abreactions which may require considerable time to deal with appropriately.

IV.2. OTHER QUALIFICATIONS FOR THE HYPNOTIST

A hypnotist who lacks basic and concrete psychological and psychopathological knowledge may be unable to recognize and cope with messages of distress or emotionally meaningful signs from the subject. Overt psychological manifestations may develop, including spontaneous abreactions, acute anxiety states, the appearance of a long uncontrollable hypnotic trance, etc. Also, neurotic manifestations such as depression or obsessive preoccupation, and decompensation of latent psychotic states may develop.

The clinician using hypnosis should have basic concrete psychological and psychopathological training in order to be able to identify and assess evident psychopathological profiles and to recognize and cope with possible psychological reactions during the hypnotic intervention.

Similarly, the professional using hypnosis should not stray from his area of expertise.

No hypnosis should be attempted untill a complete assessment has been done to rule out contraindications for hypnosis and other complicating conditions. A full assessment of each patient prior to hypnosis should be performed.
We should be mindful of the bias this may produce in our study results.

IV.3. NON-HYPNOTIC INTERVENTIONS

Counselling, supportive psychotherapy or more intense therapeutic procedures, whether conducted one-on-one or in a group setting, should be conducted or supervised by an individual with mental health training appropriate to the setting and the procedure. Such a person should also be able to identify if a participant needs help beyond his capacity, and to refer him/her to the appropriate source.

V. INFORMED CONSENT

Prospective subjects must receive, in a language which they understand, enough information about the proposed study and

Ethical Issues

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their prospective role, to enable them to decide whether or not to participate. The research protocol should outline what information is to be given to prospective subjects.

This information may include:

1. The reasons for the study.

2. Research techniques which will involve the prospective subject, such as randomization of treatments.

3. The reason why the prospective subject is being invited to take part.

4. The reasonably anticipated benefits and consequences of the study itself.

5. The reasonably anticipated benefits and consequences of the study for the prospective subject and society.

6. The forseeable risks, including discomforts and inconveniences, to the prospective subject.

7. Complete details regarding confidentiality of prospective subjects.

8. The anticipated time commitment for subjects.

9. The intent to conduct a followup study in the future and the retention of data.

10. The rules for stopping the study and withdrawing the subject.

11. The right of the subject to withdraw from the study at any time and without penalty.

In addition, the subject should be made aware of the nature of hypnosis, in particular the fact that recall under hypnosis is not necessarily more accurate than non-hypnotic recall.

VI. CONTINUING CARE OF THE PARTICIPANTS

There should be a referral process in place so that participants in an investigation in need of counselling or therapy will have this available.

VII. CONFIDENTIALITY

Dissemination of information from the therapist to the study database is to be authorized in writing by the patient; identifying data is to be erased from such information. Anonymity of the client should be respected at all times.

VIII. FEES

In determining ethical guidelines for a fee structure for therapy, the following principles should be considered:

1. Proper treatment of these subjects can involve a considerable amount of time. Hypnotic sessions in particular have the potential to consume more time than might be anticipated.

2. The professional skills involved are how the therapist earns his living.

3. It is considered acceptable to reduce or waive fees in situations of need, subject to the discretion of the therapist.

4. There is an onus on the therapist to provide followup should complications arise during the course of a treatment process.

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5. The remunerative arrangement should be openly discussed and agreed upon by both parties before treatment begins.

6. There should be no fees or other obligations for pure investigation (as distinct from therapy).

IX. LICENSED PROFESSIONALS

Licensed professionals (eg doctors, psychologists, other counsellors) whose scope of practice is governed by a licensing body or regulatory organization should seek counsel from those bodies as to how their existing rules may affect work in this area.

In some jurisdictions a professional is legally prohibited from referring a patient to an unlicensed practitioner. Although such unlicensed practitioners represent a valuable resource for both patient and therapist, clinical responsibility for a patient under the care of a licensed professional cannot be transferred to an unlicensed practitioner.

What are you thinking? Write it down and send it to me!
Comments on the contents of this issue? Areas you want to discuss?
Questions you want to pose to the community?
Think the name is dumb?
All contributions welcome!

Deadline for insertion in next issue is Jan 25.
For subscription information see Forum 3, Membership Guidelines